

Nov. 4, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Room 445-G  
Washington, DC 20201

***RE: “Make Your Voice Heard” Request for Information (RFI) – Promoting Equity and Efficiency in CMS Programs, Sept. 6, 2022.***

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) “Make Your Voice Heard” Request for Information (RFI) on promoting equity and efficiency in CMS programs. As requested in the RFI, we submitted our key recommendations using CMS’s electronic commenting tool; this letter provides the agency with additional context and information in support of our recommendations.

Hospitals and health systems face an unprecedented array of challenges as they work to sustain access to high-quality, equitable care in their communities. Among other issues, hospitals are grappling with staffing shortages, unsustainable rises in labor, supply and drug costs, supply chain disruptions, the rampant inflation affecting our entire economy, and continued disruptions from the COVID-19 pandemic. It is no surprise that hospitals are [projected](#) to face their most difficult year financially since the COVID-19 pandemic began. Hospitals are working hard to adapt to these extraordinary circumstances. However, they need CMS’ help in fostering supportive policies that fund hospitals and health systems adequately, protect patient access to equitable health care coverage, provide flexibility for more innovative and efficient care delivery approaches and relieve unnecessary administrative burden.

That is why the AHA appreciates that CMS has focused this RFI on policy areas that could meaningfully support hospitals and health systems as they navigate a profoundly



challenging environment. These areas include access to health care coverage, sustaining the health care workforce and the potential continuation of COVID-19 Public Health Emergency (PHE) regulatory flexibilities. Hospitals and health systems also share CMS' deep commitment to advancing health equity in their organizations and communities. We greatly appreciate CMS seeking input on approaches to advancing health equity generally, and the equity implications of health care coverage, workforce and COVID-19 PHE policies specifically.

Among other recommendations, the AHA urges CMS to:

- Enhance its oversight of managed care plans and Medicare Advantage Organizations (MAOs) to ensure equitable access to medically necessary care and consumer protections, and ensure those in managed care plans do not face more restrictive coverage practices;
- Adopt workforce-related policy changes that could provide short-term relief to the health care workforce and enable the health care field to adapt and innovate to meet the workforce challenges and care needs of the future, such as rethinking clinical documentation and licensure requirements;
- Advance health equity using policy approaches that strike a balance of advancing broadly applicable, evidence-based practices across the hospital field while also not being overly restrictive or prescriptive; and
- Making permanent certain COVID-19 PHE waivers, including those related to telehealth and Hospital at Home.

Our detailed comments follow.

## **ACCESS TO CARE AND HEALTH INSURANCE COVERAGE**

Significant and serious inequities exist in health care access, cost and quality for patients based on their race, ethnicity, sexual orientation and gender identity, age, and other demographic and social factors. The AHA shares CMS' strong commitment to advancing health equity, and our members are working hard to identify and address health disparities to close existing gaps in health outcomes across patient populations. We appreciate the efforts to address these inequities and believe that the agency should pay particular attention to addressing inequities in coverage offered by managed care plans, including MAOs. **Specifically, we recommend the agency address inequities in care access for managed care beneficiaries and ensure that benefit information and enrollee responsibilities for these plans are transparent, clear and accessible to all beneficiaries.**

Differences in Coverage Caused by Plan Policies. Government-sponsored managed care plans are growing in popularity amongst historically underserved communities. For example, MAOs are now enrolling higher proportions of historically underrepresented and structurally marginalized enrollees compared to Traditional Medicare, and the [greatest MA enrollment increases](#) in recent years have been among Black, Asian and Hispanic populations. As a result, addressing disparities between traditional government programs and their managed care counterparts is a critical equity issue.

One of the most important issues to address is the difference in utilization management techniques utilized by managed care plans. These can include disproportionate use of site of service policies, narrow or tiered network structures, and prior authorization. For example, the Traditional Medicare program does not use prior authorization or other utilization management techniques to nearly the same extent as MAOs. A recent Department of Health and Human Services (HHS) Office of Inspector General (OIG) [report](#) found that these aggressive prior authorization practices used by some MAOs are delaying or denying Medicare beneficiaries access to needed care. The Medicare Advantage program has nearly 27 million beneficiaries, representing 46% of the total Medicare population. Therefore, a little more than half of Medicare beneficiaries are not subject to the types of access restrictions faced by beneficiaries enrolled in the MA program. Such practices represent a structural inequity and have the potential to perpetuate disparities among patient groups. We believe **all beneficiaries of a government program should have equal access to medically necessary care and consumer protections**, and that **those enrolled in managed care plans should not be unfairly subjected to more restrictive rules and requirements**, which are unlawful and exacerbate inequities for the growing number of underrepresented and structurally marginalized enrollees.

The AHA commends CMS for collecting information regarding the adequacy of MA coverage and beneficiary access to medically necessary treatment and services. The AHA believes that some MAOs frequently misapply benefits and utilize inappropriate utilization management processes in ways that significantly impede patient access to necessary care. As detailed below, we urge CMS to carefully review MAO policies regarding prior authorization and medical necessity criteria, access to behavioral health services and post-acute care, and network adequacy (as detailed in both this section and other aspects of our response).

Prior Authorization. Prior authorization is a process whereby a provider, on behalf of a patient, requests approval from the patient's insurer before delivering a treatment or service. Although initially designed to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, many MAOs apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout and drive-up costs for the health care system.

In response to a recent AHA member survey, 95% of hospitals and health systems reported that the amount of staff time spent seeking prior authorization approval from health plans has increased in the last year. And the resource-intensive staff time spent managing health policies adds tremendous cost and burden to the health care delivery system. For example, one 20-hospital system spends \$17.5 million annually just complying with health plan prior authorization requirements. And a single 355-bed psychiatric facility needs 24 full-time staff to deal with authorizations.

Survey data also show that health plans serving public programs are more likely to deny inpatient prior authorization requests, and specifically that Medicare Advantage plans have the highest inpatient prior authorization denial rate across all payers, followed by Medicaid managed care and then commercial products. These rates vary despite physicians following the same clinical guidelines, suggesting that the denials are linked to financial, not clinical, considerations.

The federal government also has acknowledged the risk of delays in care caused by prior authorization requirements, which is why it urged health plans to ease such requirements during the COVID-19 PHE. Specifically, CMS [guidance](#) encouraged individual and small group health plan issuers to “utilize flexibilities related to utilization management processes, as permitted by state law, to ensure that staff at hospitals, clinics, and pharmacies can focus on care delivery and ensure that patients do not experience care delays.” Furthermore, in the aforementioned OIG report investigating Medicare Advantage plans, investigators found that 13% of prior authorization denials and 18% of payment denials met coverage rules and should have been granted. To protect timely patient access to necessary treatments, CMS should develop regulations controlling government-sponsored managed care plans to ensure that all patients have access to essential care and to reduce the unnecessary delays and burdens associated with inappropriate or excessive use of prior authorization.

Access to Behavioral Health. Access to behavioral health treatment is a particularly pronounced issue for managed care patients, as problematic health plan policies and designs frequently impede a patient’s ability to receive these essential services. Such problematic plan features include delayed prior authorization decisions; payment denials for care that has been pre-authorized; multiple requests for records; inadequate provider networks; unilateral, mid-year changes in reimbursement policies; and site of service exclusions.

As a result of these policies, individuals experiencing behavioral health crises are often unable to access necessary care and services and spend extended time in inappropriate settings like the emergency department while they await placement. Unfortunately, regulators have largely deferred to the dispute resolution mechanisms in provider/health plan contracts, as federal law places restrictions on the government’s ability to intervene in “contractual disputes,” leaving health plan abuses largely unchecked and patient’s left with inadequate access to treatment. **In order to ensure**

**that patients have proper access to crucial behavioral health services, CMS should increase oversight of government-sponsored plans to ensure that cost-control policies do not prevent patients from accessing covered treatments.**

Post-acute Care Services. Post-acute care (PAC) services can be some of the most challenging services for Medicare Advantage patients to access because of inappropriately restrictive health plan policies. Indeed, AHA's general acute-care hospital members report that one of their greatest sources of frustration in dealing with MAOs is the inability to get approval to move patients to the most appropriate PAC site of care. Their concerns were echoed in the aforementioned OIG report, which identified PAC as one of three services most frequently denied requests for prior authorizations and payments even when the setting or course of treatment met coverage and billing rules for the patient's condition. These types of inappropriate delays and denials for PAC services often directly harm patients, erode the overall quality of care provided and result in missed clinical opportunities for specialized therapy necessary to optimize patient recovery and function. They also undermine cross-setting clinical coordination efforts that are critical to high-quality, patient-centered care. **We urge CMS to increase oversight of applicable plans to eliminate inappropriate denials or delays to PAC services.**

Beneficiary Health Literacy. Selecting the appropriate health insurer is a crucial step for a patient to ensure that their insurance will meet their specific health care needs. Unfortunately, patients frequently make these important decisions without an adequate understanding of plan specifics. Plans can vary significantly in terms of cost sharing, covered services, provider networks and quality ratings, making it extremely difficult for an enrollee to differentiate among them and identify the best option to meet their needs. For example, MAOs routinely use prior authorization and other utilization management techniques not widely used in Traditional Medicare that may present barriers to care. The complexity of these programs may not be sufficiently conveyed to and understood by enrollees when making coverage decisions, even though it is a critical difference between MA plans and Traditional Medicare and can be essential to making an informed enrollment selection.

Health insurance literacy, defined as a person's ability to seek, obtain and understand health coverage, is essential for individuals to make educated decisions about their health care. Research has shown that low-health insurance literacy is correlated with lower socioeconomic status. Moreover, Medicare beneficiaries with low-health insurance literacy are more likely to choose plans with lower premiums and suboptimal coverage. Beneficiaries with low-health insurance literacy are less likely to understand disparate plan features and may be particularly disadvantaged when shopping in a marketplace with such a high number and wide range of options. Plan choices are often littered with narrow networks, inaccurate provider directories and ever-shifting plan-contracted providers, making it even more difficult for the average person to evaluate and understand their insurance coverage options. While evaluating benefits is

challenging for all beneficiaries, evaluating these choices is even more difficult for beneficiaries with low-health insurance literacy, which can contribute to disparities in a beneficiary's access to and use of insurance coverage. This difficulty analyzing plan choices is [further compounded](#) for those diverse patient populations with limited English-language proficiency.

Health insurance literacy and cultural humility are essential means of reducing health disparities. Indeed, cultural humility provides an ongoing process for developing a set of skills to approach individuals from any culture at any time. Therefore, it is imperative that the Administration foster inclusiveness among health insurers with the diverse communities they serve and engage enrollees and potential enrollees of diverse backgrounds in culturally sensitive ways to increase patient engagement and education. As administrators of a public benefit, these plans have a core responsibility to provide culturally and linguistically appropriate services to their enrollees. These activities are key to advancing health equity, improving patient safety and quality of care, and eliminating health disparities. **Therefore, we urge CMS to prioritize the development of policies and programs that ensure that public health plan offerings are providing enrollees with the necessary tools for health insurance literacy. Further, CMS should undertake efforts to ensure that these plans provide culturally and linguistically appropriate resources to beneficiaries with diverse values, beliefs and behaviors to meet patients' social, cultural and linguistic needs.**

## **SUSTAINING THE HEALTH CARE WORKFORCE**

A qualified, engaged and diverse workforce is at the heart of America's health care system. However, long building structural changes within the health care workforce, combined with the profound toll of the COVID-19 pandemic, have left hospitals and health systems facing a national staffing emergency that could jeopardize access to high-quality, equitable care in the communities they serve.

Prior to the COVID-19 pandemic, it was clear that hospitals would face significant structural challenges that would complicate efforts to sustain the health care workforce. In 2017, more than half of nurses were age 50 and older, and almost 30% were age 60 and older. Yet, nursing schools had to turn away over 80,000 qualified applicants in 2019 due to lack of faculty and training sites. Hospitals faced similar demographic trends for physicians, with data from the Association of American Medical Colleges indicating that one-third of currently practicing physicians will reach retirement age over the next decade. Hospitals also were reporting significant shortages of allied health and behavioral health professionals. Clinicians also reported challenges with their well-being. A National Academy of Medicine report indicated that between 35% and 54% of U.S. nurses and physicians had symptoms of burnout, which it characterizes as high



emotional exhaustion, high depersonalization (i.e., cynicism) and a low sense of personal accomplishment from work.

Unfortunately, the COVID-19 pandemic only served to deepen and accelerate health care's workforce challenges. A 2021 [survey](#) from the Kaiser Family Foundation-Washington Post found that nearly 60% of health care workers had experienced impacts to their mental health stemming from their work during pandemic, and nearly 30% had considered leaving their profession altogether. In addition, a [survey by AHA's American Organization for Nursing Leadership](#) found that one of the top challenges and reasons for health care staffing shortages reported by nurses was "emotional health and well-being of staff."

The result of these mounting pressures on the health care workforce has been stark short-term staffing shortages and a daunting long-range picture. Just within the week of Oct. 23, 2022, HHS [data](#) showed that 732 hospitals (or 18.2% of reporting hospitals) anticipated a critical staffing shortage. In addition, projections from the Bureau of Labor Statistics [estimate](#) U.S. health care organizations will have to fill more than 203,000 open nursing positions every year until 2031. There also are significant projected shortages of [physicians](#), and allied health and behavioral health care [providers](#), which would likely be felt even more strongly in areas serving structurally marginalized urban and rural communities.

**The AHA believes CMS can adopt several policy changes that could provide short-term relief to the health care workforce and enable the health care field to adapt and innovate to meet the workforce challenges and care needs of the future.** As noted later in this letter, we continue to urge CMS to make permanent many of the regulatory flexibilities adopted during the COVID-19 PHE. The PHE flexibilities described below are particularly germane to helping relieve administrative burden from the day-to-day work of clinicians.

Clinical Documentation. CMS has provided flexibility on some clinical documentation-related requirements, especially on the timeframes for completing or updating various assessments like nursing plans. While the AHA believes clinical documentation should be rigorous, clinicians often spend many hours beyond their scheduled workdays to meet the enormous demands for documentation from CMS and others. Clinician workloads have only expanded during the pandemic, and given the current and projected shortages described above, inflexible documentation requirements that do not meaningfully improve quality or safety would only compound the stress and strain on the health care workforce.

**Therefore, we urge CMS to consider retaining the flexibilities it adopted in the PHE, while working with stakeholders on a longer-range plan to rationalize clinical documentation requirements in ways that prioritize patient safety and provider well-being.** Among others, this policy development work should involve

patient safety experts, electronic health record vendors, coding and billing experts, and a wide range of clinician types.

Discharge planning. CMS waived several aspects of its discharge planning requirements, including the requirement to review detailed PAC facility quality data with patients, and to provide comprehensive listings of facilities in their geographic area. We believe there is an opportunity to reimagine these requirements in a way that preserves patient safety, equips patients and families with useful information to inform their choice of PAC providers and relieves unnecessary burden from providers.

Verbal orders. CMS provided flexibility that permits read-back verification of verbal orders to occur more than 48 hours after the order is given. While verbal order authentication remains important, providing greater flexibility on verification timeframes could alleviate burden from health care providers beyond the pandemic.

Licensure and Education. In addition to the flexibilities described above, CMS has made several other changes that give hospitals greater flexibility in deploying their workforces to meet evolving care needs and models of care. We urge CMS to make permanent the elimination of nurse practitioner practice limitations that are more restrictive under CMS rules than under state licensure. We also urge CMS to remove permanently certain licensure requirements to allow out-of-state providers to perform telehealth services.

## **ADVANCING HEALTH EQUITY**

Hospitals and health systems share CMS' deep commitment to advancing health equity within their organizations and in the communities they serve. Our members are eager to engage with CMS as it develops health equity policy approaches across its programs. Hospitals approach this critically important work recognizing that while they may be starting from different points, advancing health equity is not just a one-time activity. Rather, it is a continual process that involves engaging with internal and external stakeholders to build understanding and trust, using data to identify where disparities exist, identifying root causes, deploying interventions to address those causes, and measuring progress.

**As a general principle, the AHA believes CMS' health equity-related policies should strike a balance of advancing broadly applicable, evidence-based practices across the hospital field while also not being overly restrictive or prescriptive.** Hospitals tell us that the type, prevalence and underlying causes of inequities can differ across the communities they serve. While all hospitals may share some basic approaches to addressing inequities – such as having a strategic plan to address health equity, collecting demographic and social risk data, and analyzing those data with similar analytic approaches – the solutions they deploy are most effective when they are the most relevant to the problem being



addressed and when they are developed in partnership with the communities being served.

To date, much of CMS' health equity-related policymaking has focused on its quality measurement programs. CMS has both adopted health equity-related measures and sought to advance the use of data collection and stratification approaches that use its existing measures to identify potential inequities in quality performance. Given that one of the primary aims of health equity efforts is to eliminate disparities in quality performance and outcomes, the AHA agrees that there is an important role for health equity-related measures and measurement approaches in CMS' quality measurement programs. At the same time, we urge CMS to be mindful that there are both practical and conceptual challenges to developing meaningful and actionable health equity measures, limits to what quality measures alone can achieve, and potential unintended consequences that could stem from inappropriate use of quality measure data.

The AHA was pleased to support the three health equity-related measures that CMS adopted for the inpatient quality reporting program starting with the calendar year (CY) 2023 reporting/fiscal year (FY) 2025 payment year. However, we continue to urge CMS to adopt further improvements and clarifications to optimize their feasibility, accuracy and meaningfulness. We refer the agency to our [comments](#) on the FY 2023 Inpatient Prospective Payment System proposed rule for our detailed recommendations.

As CMS' policy development process for health equity continues, we believe the agency's efforts could be most effective to advancing health equity by focusing on:

- **Alignment and standardization of approaches to collecting, analyzing and exchanging demographic and social risk data.** This includes promoting a consistent approach across CMS itself, and across other federal agencies and programs. Given the breadth of health equity issues and the wide range of stakeholders affected by it, CMS can help ensure that all stakeholders use consistent definitions and standards. Furthermore, such standards should be thoroughly field tested before broader implementation.
- **Use of existing data to which CMS or other governmental agencies may already have access before adding new data reporting requirements.** For example, to the extent CMS is collecting demographic and social risk data during the time of enrollment in Medicare, the agency should explore ways of improving its accuracy and determine whether the data could be linked to quality measure data for hospitals and other health care providers. These steps could help provide additional data for CMS' efforts to identify disparities in performance and outcomes, while reducing the need for additional data collection by hospitals and other providers.

- **Approaches to accountability that promote collaboration over competition.** The AHA believes that advancing health equity is of such universal importance that it is vital for all public and private stakeholders to collaborate and learn from one another to address it. That is why we believe CMS should not use health equity measures in its value programs such as Hospital Value-based Purchasing, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program. In addition, while hospitals are eager to do their part to solve the persistent inequities stemming from health-related social needs (HRSNs) like nutrition and housing stability, hospitals alone cannot solve HRSNs. Addressing these challenges takes collaboration and resources from public and private sector partners. We urge CMS to avoid policy approaches that inappropriately hold hospitals solely accountable for community-level challenges.
- **Focusing hospital health equity measures on hospital-level practices and data.** Hospitals believe the foundation of their work to advance health equity should be to identify and eliminate any disparities in their care stemming from race, ethnicity, gender, sexual orientation or other demographic characteristics. The measures CMS prioritizes for implementation should focus on the structures, processes and outcomes that hospitals are most able to influence and that are shown to have a meaningful impact on improving health equity.
- **Establishing feedback loops to ensure health equity policy approaches keep up with the best available evidence.** As hospitals accelerate their commitment and resources to address health equity, we expect best practices will emerge and evolve. CMS should develop mechanisms to track these changes in practices, assess how well its existing policies align with these practices and make needed changes. CMS also should consider mechanisms for promoting learnings derived from health equity-related research across the federal government, such as from the National Institute on Minority Health and Health Disparities. We welcome new research and data on both practices that apply to a wide range of patient populations, as well as those that may work well for specific segments of communities.

## **IMPACT OF THE COVID-19 PHE WAIVERS AND FLEXIBILITIES**

The AHA deeply appreciates the support that CMS and HHS has provided over the course of the COVID-19 pandemic. The actions taken by the Administration were and remain essential in equipping our members with the tools and resources they need to manage continued COVID-19 surges, while also ensuring America's hospitals and health systems could continue to provide efficient and effective care during an unprecedented time marred by supply chain disruptions, labor shortages and workforce burnout. For example, the waivers allowed for hospital-bed flexibilities, expanded

access to telehealth services, the establishment of Hospital-at-Home programs, the ability of health care professionals to practice across state lines, and provider relief from administrative burdens. These flexibilities certainly have proven critical in our members' continued response to COVID-19, but they also have spurred significant change and innovation in supporting increased access to health care and more patient-focused approaches to care delivery.

While the duration of the PHE beyond January 2023 is unclear, it is clear that the waivers granted to respond to COVID-19 resulted in significant benefits to patient care during an extreme situation. Many of those same flexibilities have demonstrated the ability to create incredible opportunity for health care delivery and are needed now more than ever to continue to support patient access to high-quality care. For example, increased availability of telehealth services has helped [to make gains in closing the health equity gap](#) as significant increases in telehealth utilization occurred most in disadvantaged, both rural and urban, communities. Further, those same telehealth flexibilities have played a substantial role in [increased access to and utilization](#) of services focused on mental health and substance use disorder. While many of these waivers were extended by Congress for a period of 151 days beyond the PHE, **we urge the agency to take additional steps to make these critical telehealth waivers permanent.**

Like the increases in telehealth opportunities, many of our members utilized the agency's hospital-at-home waiver to manage patients with COVID-19 and those without. As our members think about investing in the future of care delivery, hospital at home not only has proven to be a successful model in managing patients during a nationwide pandemic, but it also represents a path for care delivery in the future by treating patients in their homes when possible. This model has shown remarkable potential for patients and providers by, in some instances, shortening recovery times and reducing readmission rates, managing chronic conditions more successfully and keeping older patients safe from potential exposure to illness in the hospital. All of these benefits also are accompanied by incredibly high patient satisfaction scores. While this program is set to expire at the end of the PHE, there is significant interest in extending the program for a period of two years while a permanent Hospital-at-Home program is developed and implemented. **We urge CMS to work with Congress to extend the Hospital-at-Home program and allow for the time necessary to establish a permanent Hospital-at-Home care delivery model.**

In addition to permitting new ways to deliver care, CMS, recognizing the challenging nature of the health care workforce landscape, took several steps to help alleviate those difficulties. Specifically, the agency eliminated nurse practitioner scope of work limitations so they align with state licensure requirements, while also lifting out-of-state licensure requirements to allow providers to practice across state lines, not only to help manage case surges in-person, but also to allow for broader access to telehealth services. In addition to relaxing many of the restrictive workforce-specific requirements,

actions to decrease administrative burden on staff have proven successful. For example, scaling back discharge planning requirements and allowing for verbal orders created more time for providers to focus on patient care. **We recommend the agency consider making permanent many of these flexibilities as they demonstrate a more focused approach to patient care without sacrificing the high quality and efficient nature of that care.**

Lastly, the COVID-19 pandemic presents opportunities for the entire health care sector to learn from the experiences and make adjustments to ensure preparedness now and in the future. As part of that process, it was, and remains, clear that communicating with the general public and aligning the work of the agencies within HHS is vital. For example, the work undertaken by the Food & Drug Administration to approve emergency use authorizations (EUAs) at a staggering rate was unprecedented and critical. Yet, those EUAs also require input from the Centers for Disease Control and Prevention and follow-up action on the part of CMS. We are concerned that a number of the EUAs that currently exist, such as those for ventilators, will taper off once the PHE ends and for those that do not, there will be confusion as to what is permissible to use under CMS requirements. Given the continued supply chain challenges and the overwhelming utilization of products under EUA by our membership, **we urge the agency to work with other agencies within HHS to ensure necessary alignment and communication around this important issue.**

Supplementing our comments above, please see the [AHA fact sheet](#) for additional flexibilities that should be extended. We urge you to work closely with Congress to make these critical provisions permanent.

The AHA again thanks CMS for the opportunity to weigh in on policy issues that profoundly affect the ability of hospitals and health systems to serve their community in a time of unprecedented challenges. Please contact me if you have questions or feel free to have a member of your team contact Akin Demehin, AHA senior director for policy, at [ademehin@aha.org](mailto:ademehin@aha.org).

Sincerely,

/s/

Ashley B. Thompson  
Senior Vice President  
Public Policy Analysis and Development